Protection & Advocacy, Inc.

PUBLIC AFFAIRS UNIT
555 Capitol Mall, Suite 747, Sacramento CA 95814
Telephone: (916) 497-0331 Fax: (916) 497-0813
www.pai-ca.org

Comments on Selected Recommendations from the California Performance Review Report Affecting Health & Human Resources

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Note:
The following comments are preliminary and have not, for instance, been reviewed by Protection & Advocacy's Board or Advisory Committees. Positions may change in light of further analyses and research. PAI will be submitting final comments in September.

Section II, Chapter 2, Recommendation that Services for People with Disabilities be Consolidated into two divisions: Behavioral Health Division and Services to Disabled Division
Position: **Oppose with reservations**
and
HHS15
Recommendation that Drug & Alcohol and Mental Health Services be Consolidated
Position: **Support with reservations**

Consolidation of services for people with disabilities into two divisions raises a number of concerns about coordination of services. On the one hand, there is a possibility that coordination of some services can be improved. This includes coordination of mental health and substance abuse services, although this is questionable if the system for billing for services is not improved.

Unfortunately, there are many areas of service that will not be coordinated by this consolidation. It is impossible to coordinate all services. However, consolidation in the manner proposed may exacerbate the existing coordination problems. Consolidation also suggests that certain services are more appropriate for coordination than others.

For example, there would be a benefit in better coordination of mental health and substance abuse services. However, difficulties in coordinating Regional Center and county mental health services for people with both developmental and psychiatric disabilities is an ongoing problem that is equally great. The split in the divisions between people with psychiatric disabilities and other disabilities will not even begin to address this problem. The split may suggest that this problem is no longer a concern when, in fact, it continues to be a major concern.

Consolidation of State mental health and substance abuse programs.

There is a great deal of merit to coordinating mental health and substance abuse treatment services for individuals who need both services. However, consolidation of the Department of Mental Health and the Department of Alcohol and Drug Abuse will not, by itself, provide the solution. The main difficulty with the current system is that there is no effective mechanism for billing the appropriate program when the *same* service is directed at addressing *both* mental health needs and substance abuse. This problem has to be resolved or consolidation will be meaningless.

There is also a concern that the focus on "behavioral health" will create additional stigma for people with a diagnosis of mental illness. The following are some of the reasons:

1. The focus on "behavior" suggests that the causes of mental illness are similar to the causes of substance abuse, and that the approach to providing services should be similar. The recovery model for providing mental health services is, in many respects, based on the recovery model used for providing substance abuse services, but there are differences that should not be minimized.

2. The proposal would create two divisions focusing on services to people with disabilities. One division for people with developmental and physical disabilities, and the other for people with psychiatric disabilities. The mission of the division for people with developmental and physical disabilities is "… to provide a high quality continuum of care to the developmentally and physically disabled. The Center should be the focal point for California's special needs population." On the other hand, the mission of the "behavioral health" division would be "… to oversee

the application of state and federal laws in both county-operated programs and state-operated facilities." This suggests a distinction between the needs of people with psychiatric disabilities as compared to people with other disabilities. In fact, there is no distinction. Both groups need a high quality continuum of services. Separating the two groups encourages the drawing of inappropriate distinctions. It encourages people to think in terms of people with "good" disabilities and people with "bad" disabilities.

SO 70
Using State's Collective Purchasing Power to Control Drug Costs
Position: **Support**

This recommendation calls on the State to use its collective purchasing power - whether through Pharmacy Benefits Managers or otherwise to maximize savings. The recommendation would save taxpayer dollars. PAI recommends that before any approach to use the State's combined purchasing power, that the State review the Veterans Administration's cost effective drug purchasing program. See, e.g., http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=103287

GG07
Maximize Federal Grant Funds
Position: **Support**

The recommended proactive approach to maximizing federal grant funds should improve access to federal grant funded services and save California taxpayer dollars. While California, like other States with larger populations, will always be at a disadvantage with respect to the amount of federal taxes returned to the State, we believe the strategies recommended would enable California, which receives 77¢ back for every federal tax dollar sent to Washington, to move closer to New York which receives 85¢ back for every federal tax dollar.

HS01
Transform Eligibility Processing for Medi-Cal, CalWORKS, Food Stamps
Position: **Support some of the elements with qualifications**

Our comments here are limited to the Medi-Cal program. We do not have the experience with foodstamps or CalWORKS to comment on the proposal with respect to those program.

We support the use of information from one program to establish eligibility in another program or to minimize the need to get additional information from the applicant. We also support simplification through self-reporting of assets – or expanding the number of programs where assets are not counted at all. And we agree that particularly in the larger counties processing of applications is rife with error. Even when a PAI client is sent into a County Medi-Cal program with a memo from PAI asking that the County determine eligibility for an adult under the 250% Working Disabled program or a child under the Aged & Disabled Federal Poverty Level Program it does not happen.

However we do not agree that the Healthy Families – Medi-Cal joint application is a good model. That application is flawed in that it does not identify children who may be eligible for no-share-of-cost Medi-Cal on the basis of disability or because a member of the child's family has a disability. There is not one single question on the application form that would trigger a further investigation to see if the child would qualify for Medi-Cal on the basis of disability. As a consequence the Healthy Families – Medi-Cal application shunts to Healthy Families children who would be eligible for Medi-Cal with no share of cost under either the Aged-Blind-Disabled (ABD) Medically Needy (MN) program[1] or the Aged & Disabled Federal Poverty Level (A&D FPL) Program[2] into Healthy Families. Because the application does not ask whether other children or a parent qualifies for SSI, the application does not identify children (and a parent) who would be eligible for Medi-Cal with no share of cost because family income that already has been counted for purposes of determining eligibility for SSI cannot be counted again

[1] Under the ABD MN program, if one child qualifies for Medi-Cal with no share of cost, so would the other children in the family – and possibly also the parent or parents. The ABD MN program treats earned income the same way as the SSI program – namely by a $20 and $65 deduction plus another 50% deduction. Under the Maintenance Need Levels we have lived with since July of 1989, the two or three children in a family of four would qualify for no-share-of-cost Medi-Cal if the family's gross earned income did not exceed $2285 in a month.

[2] *See* PAI's 2004 worksheet for determining the Medi-Cal eligibility of a child with disability under the Aged & Disabled Federal Poverty Level Program: http://www.pai-ca.org/pubs/524401.pdf

under the Medi-Cal program. Cal. Code Regs., tit. 22 § 50555.1. Finally, the application form does not ask whether the "mother" or "father" may be a stepparent whose income would not count under federal rules - 42 U.S.C. § 1396a(a)(17) – and therefore triggering a need for more information.

The purpose of the discussion of problems with the current joint Healthy Families – Medi-Cal application particularly for children with disabilities is not to rail against it but rather to underscore the pitfalls in attempting to "simplify" which ends up denying eligibility and services to currently served groups. For instance, suggestions to simplify by reducing the number of Medi-Cal aid codes or simplifying the income or resource rules often would have the effect of denying eligibility and services to the extent the simplification does not follow the most generous standards applicable.

While there is a role for community based organizations and contractors in assisting persons in accessing the application process, for purposes of accountability, transparency, and responsiveness, we would oppose contracting out eligibility determinations because they are a uniquely governmental function.. Despite Los Angeles County's LEADER disaster, a better solution would be to develop a computer program that would prompt eligibility workers through the application process.

We would support expanding the use of the internet in the application process because it would improve access for those able to use the internet but not if doing so would close or narrow other doors to the application process – namely, in person or via the mail. Availability of an eligibility worker is an important resource for many of PAI's clients. Indeed, for purposes of Medi-Cal applications, there should be evening hours at least once a week.

HHS02
Realigning the Financial Administration of Certain Health & Human Services
Positions: **Support with significant qualifications shifting financial responsibility for medically indigent adults to the state.**
Support shifting financial responsibility for the IHSS program to State
Oppose shifting the whole of financial responsibility for Medi-Cal mental health services to the County.

Medically Indigent Adults: This is a proposal that requires much more information to enable us to take a position. We would support shifting financial responsibility back to the State for medically indigent adults and integration of the MIA program

back into the Medi-Cal program. To support any programmatic aspect of such a proposal PAI would need much more information. As an interim measure, the State should support the County initiated proposal to seek a Medicaid Waiver covering MIAs funded through unused SCHIP funds plus savings from preventive services to persons with disabilities such as diabetes not yet severe enough to meet the SSI disability standard.

IHSS Program: We agree that shifting financial responsibility for the IHSS program to the State would enhance the program's ability to save money by avoiding or delaying placement in a medical facility. We hear reports from clients about counties urging high-hour cases to consider nursing facility placement.

Medi-Cal Mental Health Services: We oppose shifting to the County existing State financial responsibility for Medi-Cal mental health services delivered or authorized by local Medi-Cal Mental Health Plans. We oppose reduction of the State's responsibility to ensure Statewide access to medically necessary Medi-Cal mental health services. Access to medically necessary Medi-Cal mental health services is an entitlement just as access to other medically necessary Medi-Cal services such as kidney dialysis is an entitlement. We oppose treating Medi-Cal mental health services as somehow second class services.

HHS21
Consolidate Licensing and Certification Functions
Position: **Oppose**

There is some merit to combining state licensing functions in terms of recruitment and training of qualified licensing personnel. However, there have been chronic and almost intractable problems with large licensing agencies developing the expertise to oversee facilities that provide particular types of services. For example, State Department of Social Services Community Care Licensing has often demonstrated a lack of understanding of how board and care facilities can provide appropriate services to people with physical disabilities. The response has often been to remove individuals from appropriate board and care placements and cause unnecessary institutionalization. The same is true with respect to proper treatment of individuals with psychiatric disabilities. Consolidation in our opinion would exacerbate the arbitrariness of Licensing.

In general, the trend has been to give the licensing function to departments that have the expertise in providing services to the individuals in the licensed facilities. At times, the smaller agencies have had difficulty developing the general expertise

common to all licensing functions and that may be an area where efficiencies could be achieved.

HHS24
Securing Full Financial Participation for Services to Residents of ICF/DD facilities
Position: **Support**

As reflected in PAI's comments and suggestions to the Medi-Cal Redesign process, PAI strongly supports initiatives for federal financial participation in the cost of all services provided to residents of Intermediate Care Facilities for persons with Developmental Disabilities. PAI strongly supports the hiring of consultants to assist in the state plan amendments to secure additional federal funding for services in the community during the day and transportation costs to and from the community – services which are currently funded with solely state funds.

PAI also agrees that in light what is expected to be a more aggressive CMS review in fiscal year 2005 of the State's home and community based waiver for persons who qualify for services from regional centers, additional staffing or consultant assistance is needed to ensure California does not lose any of the federal participation in the cost of community services to persons who would otherwise qualify for ICF/DD care.

Finally, PAI further recommends that the eligibility criteria for admission to an ICF/DD be amended to bring them in line with other states such as New York. Such a change would enable California to expand the scope of its current Home and Community Based Services waiver for persons who are regional center clients so that additional state funds for community services to regional center clients can be replaced with federal Medicaid funds.

HHS25
Competitive Bid Process for Durable Medical Equipment
Position: **Support with Qualifications**

PAI would support the State using its collective purchasing power to reduce costs for durable medical equipment. That support is contingent on the process not limiting the scope – or on having the effect of limiting the scope by reducing access - of equipment currently available upon a showing of medical necessity. PAI's clients include persons who rely on complicated equipment and who need individualized features to maximize their ability to function and function independently. That access

needs to be preserved.

PAI would further recommend that competitive bidding also be considered for medical supplies.

HHS26
Maximize Federal Funding by Shifting
Medi-Cal Cost to Medicare
Position: **Support maximizing enrollment in Medicare**

PAI supports the recommended initiatives to enroll more people into Medicare. For instance, California could, if it elected to do so through arrangements with CMS, enroll seniors who could qualify for Part A Medicare upon payment of the fee throughout the year rather than only in the current January-March window.

In addition, because of a change in federal law going into effect this year, persons who once qualified for title II Social Security Disabled Adult Child (DAC) benefits based on the earnings record of a parent but lost eligibility because of work activity can qualify again for DAC benefits and Medicare. PAI has requested that the Social Security Administration work with state programs serving persons with developmental disabilities to enlist their help in identifying those who may be eligible to requalify for DAC benefits and Medicare.

HHS27
Identifying Other Health Care Coverage
Position: **Support with qualifications and only if an Amendment to the State Plan to enable Medi-Cal beneficiaries to actually use OHC and if the State Improves it Health Insurance Premium Payment Program**

PAI supports accessing private health benefit plans before accessing Medi-Cal. However, before OHC is added to the Medi-Cal recipient's AEVS file, protections need to be in place to ensure that the identified OHC is actually available to the Medi-Cal recipient. For instance, the OHC may be geographically unavailable because provided by the absent parent's workplace. Or the plan providers may not participate in Medi-Cal and refuse to accept Medi-Cal to cover deductibles and copayments[3] – a

[3] There is no incentive for a provider who does not otherwise participate in Medi-Cal to accept Medi-Cal because the Medi-Cal rate is usually less than what the provider would receive

frequent occurrence with CHAMPUS participating providers for instance. If OHC providers will not accept Medi-Cal for copayments and deductibles, then the OHC is unavailable to the Medi-Cal recipient because, at least currently, Medi-Cal recipients cannot be required to pay the $10-$20 copayments for office visits.

To maximize OHC, we recommend that California follow the Iowa model to assist persons in enrolling in available health care coverage. See, for instance, the following descriptions of the Iowa program:

http://www.medi-calredesign.org/pdf/elig_McColrmack_Iowa_prem_pmnt%20prog.pdf
http://www.ncsl.org/programs/health/buyin03.htm
http://www.insuretexans.org/papers/sec2_apph.pdf
http://www.workworld.org/wwwebhelp/health_insurance_premium_payment_hipp_.htm

To improve access to OHC, California needs to do what other states including Iowa do: pay the copayment and deductible when it is cost effective to do so. The current system of only paying a copayment or deductible when the cost paid by the plan without the deductible or copayment is less than what Medi-Cal would pay if it were the sole payor is not ultimately cost effective. While this approach makes sense for those whose OHC is Medicare because people are not going to drop Medicare, it does not make sense where people have the discretion to drop health care coverage and frequently elect to do so when the OHC complicates access to health care. The State's policies should encourage accessing OHC because it links people up to a medical home.

Finally, even if the State does not opt for a program like Iowa's to actively enroll people in available private health plans, the State needs to improve its current HIPP program. The current program will not cover premiums for months prior to approval. Some people still in their COBRA window are unable to handle the premium costs for a prior month with the effect of both the Medi-Cal recipient and the State losing the benefits of OHC.

HHS30
Centralize the TAR Processing system
Position: **Oppose at this time.**

Instead of further consolitation, the emphasis should be on reducing the number of items and services that need to be TAR'd, improving the guidelines for identifying TARs that should be approved to reduce the number that require individual attention.

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before any copayment. And, unfortunately, DHS has advised that it will take no action against a provider who does participate in Medi-Cal to accept Medi-Cal from someone who has OHC.

The TAR process is already centralized with respect to specific categories of services. For instance, TARs for durable medical equipment are handled out of the San Franciso Field Office. Further consolidation would mean expertise would be lost in the process. PAI believes more effort should be directed to reducing the costs of processing TARs by improving guidelines for TAR approvals and identifying services and equipment that could be excluded from the TAR process.

Finally we do not believe DHS is sufficiently automated to have the case managers totally telecommute. Further, they need support services in order to be effective.

HHS32
Transfer the IHSS program from DSS to DHS
Position: **Oppose**

PAI opposes the transfer of the administration of the IHSS and Medi-Cal Personal Care Services (PCS) programs to DHS. To do so would threaten the social model that has made the programs effective and move the programs instead toward a medical model program. Further, in the instances where DHS has been involved with IHSS/PCS it has done a poor job. Don't fix what is not broken.

In 1992 and 1993 when the state moved to access federal Medicaid funds for part of the IHSS program, great care was taken to maintain the social model program character as desired by the community when accessing federal Medicaid funds. During that time period Medicaid coverage of personal care services that had been covered only under the federal regulations was formally added to the statute. California advocates worked with advocates in other parts of the country to remove the requirement that the delivery of personal care services be overseen by nurses. The removal was to maintain client control of the program in California and to preserve the program's social model character but also to reduce unnecessary costs in the operation of the program.

The community's experience with DHS in implementing AB 688 also supports keeping IHSS in DSS. AB 688, sponsored by ADAPT, required DHS to amend its nursing facility home and community based waivers so that persons who qualified for waiver services could elect waiver personal care services to supplement personal care services available under the State Plan instead of nursing services. First there were years of delay in implementing the provision at all. Next there were years where the State would only authorize waiver personal care services if the person were receiving 283 hours a month even though the person was receiving all the personal care hours

that could be authorized under the state plan. While currently DHS recognizes that waiver personal care services can supplement any hours authorized under the state plan, there are still continuing and serious problems integrating the delivery and payment of waiver personal care services with personal care services authorized through the county.

The differences in administration and attitude was also seen in how the two departments implemented the Aged & Disabled Federal Poverty Level (A&D FPL) when that program went on line in January of 2001. DSS from Sacramento converted the share of cost Medi-Cal personal care services recipients to the A&D FPL sending to the County only the cases with questions. DHS, which also could have converted the bulk of the ABD MN cases to the A&D FPL program instead shipped the task to the Counties at the last minute. As a consequence, while we never saw someone who received Medi-Cal personal care services but who should have been transferred to the A&D FPL program who was not, we saw lots of folks who did not receive Medi-Cal personal care services and who should have been transferred from ABD MN to the A&D FPL program but were not.

HHS33
Eliminate Dual Capitation for Medicare/Medi-Cal Managed Care Plans
Position: **Oppose pending more information**

With respect to COHs, dual eligibles have to be enrolled in COHs because there is no fee-for-service access except through the COHS. Our experience is that the COHS provider rates are higher than the fee-for-service rates. There are no providers accepting fee-for-service Medi-Cal outside of the COHS. For services not covered by Medicare – or where there is a discrepancy in the coverage between the programs[4] – access to services would only be through the fee-for-service feature of the COHS. While some reduction in the capitation rate may be in order, we would want to ensure that the rate captures the extra adminstrative costs involved in serving dual eligibles.

With respect to nonCOHs dual eligibles, we need more information before a position can be taken. We are concerned that this recommendation targets participation in PACE, a program designed for dual eligibles who would otherwise require care in a nursing facility. Reducing or eliminating the Medi-Cal capitation would jeopardize the viability of PACE.

[4] Medicare does not cover home health care when the person does not meet the Draconian Medicare "homebound" requirement; that requirement does not apply to Medicaid. Medicare only covers DME used in the home; Medicaid covers DME used in the home and in the community.